Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		IBENTI TO ATTOM NO		A. BUILDING		R-	.c
		157579		B. WING			7/2012
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	M ST IELD, IN 460 <sup>,</sup>	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{N 000}	Initial Comments			{N 000}			
	health agency compla	revisit for a state home aint investigation survey 08, 2011, with the first	,				
	Survey Dates: March	n 5, 6, and 7, 2012					
	Facility #: 004091						
	Medicaid Vendor #: 200806840  Surveyors: Susan E. Sparks, RN, PHNS, Team Leader						
			eam				
	Bridgett Bosto Member	on, RN, PHNS, Team					
	Kelly Hem Supervisor	melgarn RN, PHNS,					
		ere found corrected and ited with this survey. F e cited.					
	Quality Review: Joyc March 9, 20	e Elder, MSN, BSN, RN 12	1				
	This survey was mod 4/4/12. je	ified as the result of an	IDR				
N 416	410 IAC-17-10-1(k) L	ICENSURE		N 416			
	surveyor shall receive documents necessary compliance. The sur- following:	conducting a survey, a e copies of any and all y to make a determinativeyor may do either of the permission of the h	the				

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
				A. BUILDING B. WING		R-	.c
		157579		D. WING		03/0	7/2012
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	M ST IELD, IN 460	17		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
N 416	Continued From page 1			N 416			
N 410	health agency.  (2) Supervise any cophotocopies are true. At the sole discretion good cause shown, the granted up to twerproduce documents rouse of the produce documents of the sased on clinical recoagency failed to ensu documents for determine the findings include:  1. Clinical record # 2 was provided to the produce documents for determine the produce of the provided to the provided to the produce of the provided to the provi	and accurate. of the department and the home health agency onty-four (24) hours to requested by the survey of as evidenced by: ord review and interviewed and interviewed (#21).  If failed to evidence can be a failed to evidenc	for may vor. v, the were re 7, cated n ent #	IN TIO			
	the mail. They expect delivered by the Unite Wednesday March 7,	ed States postal service	e on				
	3. On 3/7/12 at 12 PM, employee FF indicated that they received their mail delivery for the day and the visit notes for clinical record # 21 had not been received.		day				
		ce was conducted on 3/ eceipt of the documents					
N 446	410 IAC 17-12-1(c)(3 administration/manag	) Home health agency gement		N 446			
	Rule 12 410 IAC 17-1	12-1(c)(3)					

Indiana State Department of Health

	TEMENT OF DEFICIENCIES O PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	157579			A. BUILDING B. WING			R-C <b>07/2012</b>
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABU	CJ'S ABUNDANT CARE 523 W F CHESTE			M ST IELD, IN 4601	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
N 446	Continued From page 2			N 446			
	Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations.  This RULE is not met as evidenced by: Based on administrative document review and interview, the administrator failed to ensure all of the agency personnel received adequate education for 1 of 2 agency sites with the potential to affect all the patients served by the non-inserviced site.						
	Findings include:  1. The untitled administrative document dated 1/26/12 stated, "Plan of correction for ISDH / CMS was gone over with [employee FF] and [employee EE] on 1/25/12. When asked [employee DD], if she and [employee F] were going to initiate the inservices as put in the POC [plan of correction] to start on 1/26/12, no answ was given. [employee DD] RN, administrator, n [employee F, RN, DON [director of nursing] initiated inservices for 1/26/12. After collaborating with [employee EE] RN, Clinical Coordinator, it was decided that she should initiate inservices for POC. Due to the unavailability of administrator / DON they were not present for inservices so therefore no signatures will be obtained on inservice sign in sheets." The document was signed by employee EE and FF.		e POC Iswer or, nor al				
	-	5 AM, employee FF tive documents to evide I that provided patient o					

Indiana State Department of Health

AND PLAN OF CORRECTION	IDENTIFICATION NUMBE	LIA :R:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157579		A. BUILDING B. WING		R-C <b>03/07/2012</b>
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	00.01.2012
CJ'S ABUNDANT CARE		523 W PLUM CHESTERFI	/IST ELD, IN 4601	17	
PREFIX (EACH DEFICIENCY MUS	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
N 446 Continued From page 3	Continued From page 3				
received adequate education documents evidenced multiple education was presented at the Attendance dated January 1:30 PM, stated, "Topic: In Management / documentation and depression [employee EE]." The documentation on February Ediven by [employee FF] Lattendance Employee FF] Lattendance FF] Lattendance Employee FF] Lattendance FF] Latte	and included:  ant titled "Inservice ry 26, 2012, from 1 n-service on Pain ation / meds with Own intervention, giver ament indicated that the street of the service on Pain ation / meds with Own intervention, giver ament indicated that the service of the service	P to ASIS n by t vith ated, " tion  e" op N ] 14 N to RN ed s II visit. ch eed with ee" me 3 nt all fore ilies	N 446		

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE S COMPL	
		157579		B. WING	·		R-C
NAME OF PR	ROVIDER OR SUPPLIER	157579	STREET ADD	<b> </b> RESS, CITY, STA	TE. ZIP CODE	03	/07/2012
	NDANT CARE		523 W PLU				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 446	Continued From page 4			N 446			
	indicated that employ presented with the inf 2012, and stated, "Giradministrator." The d Employee KK, the brawith the information o 2012, and the docume [employee FF] LPN, a D. The document indicated ewas presented with the information o 2012, and the document indicated ewas presented with the 25, 2012, and contain [employee FF] LPN, a document indicated the solution of the indicated the indicated the indicated the indicated the indicated the indicated with the indicated th	edministrator."  cument titled "In-service 2/12, start time 10 AM a tated, "Topic: In-service sure ulcers, Braden scassessments." The ated by employee EE. mployee II, the branch he information on Februard the statement, "Given administrator." The nat Employee KK, the sented with the informat, and contained the	25, LPN, ed ry 27, e and e - On ale, The RN, eary en by				
	E. The document titled "In-service Attendance" dated 2/3/12, start time documented was "8 - 10:50 AM" and stop time was documented as "1:45 PM - 4 PM" stated, "In		ented				
	document stated, "To nurse: Not performing [care plan] or perform [patient] / caregiver if The in-service was pr The document indicate branch RN, was pression February 25, 2012	picked up checks." The pic: What to report to the grasks that are not on ing tasks requested by not on CP [care plan]." esented by employee Elect that employee II, the ented with the information. The document failed it. Was presented with the	ne CP pt EE. e ion to				

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPL	
		157579		B. WING	·		R-C <b>/07/2012</b>
NAME OF PE	ROVIDER OR SUPPLIER	157579	STREET ADD	<b> </b> RESS, CITY, STA	TE, ZIP CODE	03	0772012
	NDANT CARE		523 W PLU				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 446	Continued From page 5			N 446			
	information.						
	and dated 2/10/12, sta 9:15 AM and stop time AM, stated, "In-service have individualized Perequired elements are [employee FF], LPN, document indicated ewas presented with the 25, 2012, and contain [employee FF] LPN, a G. The document indicated ewas presented with the 125, 2012, and contain [employee FF] LPN, a G. The document indicated ewas presented with the information on Fercontained the statement of the statement of the statement information on Fercontained the statement information of the statement information information of the statement information information of the statement information	mployee II, the branch me information on Februard the statement, "Given administrator."  cument titled "In-service 10/12, start time 9:50 A stated, "Topic: In-service pected problems which are or safety to administin-service was present ocument indicated ch RN, was presented bruary 25, 2012, and ent, "Given by [employed or." The document indicanch LPN, was present in February 27, 2012, and ent, "Given by [employed or." Given by [employed or." The document indicanch LPN, was present in February 27, 2012, and ent, "Given by [employed or." Given by [emplo	as 9:45 Jist IIII  RN, Jiary Jien by  M Ce - In Trator Jied by  with  ee cated ed nd				
	dated 2/10/12, start till PM, stated, "Topic: In-	eument titled "Attendand me 2 PM and stop time -service - Nurses to foll	2:30 low				
	all new orders given to was presented by em	urrent 485 / plan of care o nurses." The in-serv ployee EE. The docur	rice				
		ormation on February 2 the statement, "Given b					

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		457570		B. WING		R-0	_
NAME OF DE	ACMIDED OD OUDDUIED	157579	STREET AND	RESS, CITY, STA	ATE ZID CODE	03/07	//2012
NAME OF PR	ROVIDER OR SUPPLIER				ALE, ZIF GODE		
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	FIELD, IN 460	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
N 446	Continued From page 6			N 446			
	document indicated Employee KK, the branch LPN, was presented with the information on February 27, 2012, and contained the statement, "Given by [employee FF] LPN, administrator."  I. The document titled "In-service Attendance" dated 2/10/12, start time 3:45 PM and stop time 4:00 PM, stated, "Topic: In-service - Upon admission RN will speak with client / caregiver / MD to see if there are any outside						
		e for the patient." The	<del>-</del>				
	in-service was presented by employee EE. The		The				
		nat employee II, the bra					
	RN, was presented w	ith the information on					
	February 25, 2012, ar	nd contained the staten	nent,				
	"Given by [employee	FF] LPN, administrator	."				
	I The doc	ument titled "Attendand	۰۵"				
		me 4 PM and stop time					
		-service - On the highli					
		ned document was title					
		ntry" and indicated the	•				
		ted from the Indiana St	ate				
	•	Survey Report System					
		resource locator] was					
	the bottom of the doc	ument and was dated					
	2/12/12. The docum	ent was initialed by 8 s	taff.				
	The sign in sheet doc						
		ment referenced was d					
		could not be determined					
		ented during the educa					
		nt indicated employee I					
	·	ented with the informat	ion				
	on February 25, 2012						
	statement, "Given by						
		ocument indicated that					
		anch LPN, was present n February 27, 2012, a					
		ent, "Given by [employe					
	FF] LPN, administrate						

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		A. BUILDING		(X3) DATE SUF COMPLET	ED
		157579		B. WING		03/0	7/2012
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	M ST IELD, IN 460 <sup>.</sup>	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
N 446	6 Continued From page 7			N 446			
	dated 2/10/12, 7 PM - Company policies and Federal Guidelines." by signature and inclu FF, and JJ, all administration of Care, Skilled Nurse In The Topics included with the home Care Nurse responsibilities for particular documentation of care Sheet. 4) CJ's scope "Liability for Payment consent form. 6) For packet to demonstrate Plan of Care Workshoutilized to complete received to Care Form and Receive of Sentinel Experience of Care Form and Receive of Care Form an	ument titled "CJ's Abunn - Service date: 2/29/1 vere 1) Role and function. 2) RN Case Manager tient care and e provided. 3) Assignm of service. 5) Form for Addendum" - review thems added to the admission best practice. 7) 485 vet. 8) Clinical Forms equired processes. 9) Conference / Coordinative of Process. 11) vents. 12) Competency mplemented in next 1-vice was presented by the administrative vidence the branch added and presented with the document evidence of J, and LL (administrative ended and received the discourse of the service of the discourse of the service of the document evidence of J, and LL (administrative ended and received the discourse of the service of the	d ted E, dant 2." on of ent his sion / tion 2 the d only re				
	employee EE had acc director of nursing on FF indicated she had	cepted the position as the same date. Emplo thought that employee of nursing and the full to	F,				

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/		(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE S COMPL			
		.52.111671611.116		A. BUILDING			R-C		
		157579		B. WING			3/07/2012		
NAME OF PR	ROVIDER OR SUPPLIER	•	STREET ADD	DRESS, CITY, STAT	TE, ZIP CODE				
C IIC A D. II	NDANT CARE		523 W PL	523 W PLUM ST					
CJ 9 ABU	NDANT CARE		CHESTER	IESTERFIELD, IN 46017					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)		
PREFIX TAG		ICY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLETE DATE		
IAO			,	IAO	DEFICIEN				
N 446	V 446 Continued From page 8			N 446					
1	registered nurse at t	the branch, was going to	)						
		vices and present the							
		or the patient care staff	of the						
1	branch. She indicat	ted she discovered after							
1	employee F left emp	ployment on 2/21/11, the	<del>)</del>						
1		completed for the branch							
		then educated employed							
		ree KK on 2/27/12 during ent # 21. She indicated							
	I								
only personnel remaining from the branch and providing patient care were employees II and KK.  4. On March 7, 2012, at 10 AM, employee KK									
		ΚK							
		me she was presented v							
	in-service and educ	ational material was whi	le she						
		patient # 21 on February	/ 27,						
	2012.								
{N 522}	410 IAC 17-13-1(a)	Patient Care		{N 522}					
ı	Rule 13 Sec. 1(a) N	Medical care shall follow	а						
	written medical plan	of care established and	l						
		d by the physician, dent							
	chiropractor, optom	etrist or podiatrist, as fol	lows:						
	This DIII F is not m	net as evidenced by:							
1		cord and policy review a	nd						
		by failed to ensure treatn							
		dered on the plan of car							
	•	reviewed of patients wit							
		ces with the potential to							
	all the agency's pati	ents. (# 21)							
ı	Findings Include:								
	Clinical record 2 <sup>-</sup>	1, start of care 10/27/11,							
		care for the certification							
	period 2/24/12 throu	ugh 4/23/12 with orders t	or						
		ervices. The clinical reco							
	evidenced a docum	ent titled "Recertification	1						

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STATE FORM 6899 6WIQ13 If continuation sheet 9 of 24

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
				B. WING			-C
		157579				03/0	7/2012
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	M ST TELD, IN 460°	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{N 522}	Continued From page 9			{N 522}			
	by employee II, that in wound located on the the assessment titled stated, "Turgor: Good wound." The area of "Wound Care" states, nickel, no active drain skin blanching, around assessment titled "Wo"Location L [left] heel, Tunneling: no, Odor: and blanching, Edema Appearance: no active area, Drainage / Amo serosanguineous." The "Sore on L [left] heel is and symptoms] of infeddays per orders."	"Comments: Wound s lage / bleeding. Open, g d wound." The area of bound / Lesion" stated, Type: diabetic foot ulc no, Surrounding Skin: r a: +1, Stoma: No, e drainage, yellow sero	d one ea of " was pen ize of good the er, ed us d, signs 2				
	that identified the patidiagnosis of diabetes 250.00 and orders that 2 times a day, 3 X [tintimes a day, 7 X W X assessment teach vis prn. [if necessary] injections twice daily. every other week and compliance / effects.	ent had a principle mellitus type II ICD -9- at stated, "SN [skilled n nes] W [week] X 1 W, tl 8 W for: SN to pe it and vital signs daily, administer to patient ir Preset oral medicatior to monitor for medicat SN to change dress	CM urse]: hen 2 rform and nsulin ns ion				
	compliance / effects SN to change dressing to left heel every other day with sterile telfa, wrap with gauze wrap then ace bandage until client is seen by wound clinic in Connersville on 3/9/12 SN to monitor disease process of IDDM / MD / Cardiac. Perform glucometer check each visit and record. Observe skin for possible signs of breakdown, and feet for proper care." The clinical record failed to evidence an assessment						

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPL	ETED	
		157579		B. WING		R- 		
NAME OF PE	ROVIDER OR SUPPLIER	107075	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		10112012	
CJ'S ABUNDANT CARE			523 W PLU CHESTER	IM ST FIELD, IN 4601	17			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
{N 522}	B. The clinical retitled "Nursing Visit NAM completed by emstated, "PO [oral] med MD orders dressing pillow." The skilled nacomplete skin assesincluded an assessmifeet. The record failed the nurse to administration of the completed by emsure and the completed by emsure and the completed by emsure and the complete skin assessincluded an assessmifeet. The record dressing propped up with pillow the skilled nurse note complete skin assessincluded an assessmifeet. The record failed the administration of the complete skin assessincluded an assessmifeet. The record failed the administration of the completed by emsure and the completed by emsure and the completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name completed by emsure and the clinical retitled "Nursing Visit Name co	uded complete ne appearance of the operation of the patient of the operation of the patient of the operation	per p on ence that nt's for side."  talents:30  well, nity] side."  talents is on the control of	{N 522}				
	and stated, "Telfa, AE to LLE [left lower extr note failed to evidence assessment was com assessment of both of	changed a wound dres BD pad, kerlix, ace band emity]." The skilled nuite that a complete skin apleted that included an of the patient's feet.	dage rse					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING		(X3) DATE SURVEY COMPLETED	(
		157579		B. WING		03/07/20	012
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABUNDANT CARE			523 W PLU CHESTERF	M ST TELD, IN 460°	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE C	(X5) COMPLETE DATE
{N 522}	PM completed by em "VS done in am, pain complete, insulin & Po orders, tolerate well, i @ side." The skilled evidence that a comp completed that includ the patient's feet. The an order for the admin medications.  F. The clinical retitled "Nursing Visit No PM completed by em "VS done in am, pain [unknown] complete, MD orders, tolerate wis clean, dry, and inta Alert system @ side." failed to evidence tha assessment was com assessment of both orecord failed to evider administration of oral  G. On March 7, KK, a licensed practic was not a plan of care she began providing selivered to the home she was providing the verbal orders given to registered nurse in che 2/21/12. She indicated patient's medications the patient's feet at al She indicated she was the patient's feet was	ote" dated 2/25/12 at 6: ployee KK. The note stands assessed, OT [unknown O meds given per MD meal provided. Alert synurse note failed to lete skin assessment weed an assessment of be record failed to evidentistration of oral  ecord evidenced documpote" dated 2/26/12 at 6: ployee KK. The note stansessed & charted, Coinsulin & PO meds give rell, meal provided, drest ct will continue to monit of the skilled nurse note that a complete skin apleted that included an fight the patient's feet. The note an order for the	tated, wn]  stem  stem  stated, stem  stated,	{N 522}			

Indiana State Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			1` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING	<u> </u>		R-C	
		157579				03	3/07/2012	
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
CJ'S ABU	CJ'S ABUNDANT CARE			JM ST FIELD, IN 4601	17			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
{N 522}	Continued From page	e 12		{N 522}				
	the patient always had slippers and stockings on both feet and that she had not removed them to assess the skin on the patients' feet.  2. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services."  3. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician."  4. The policy titled "Skilled Nursing Services" states "Skilled nursing services will be provided by a Registered nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's							
N 537	orders).	cone of Services		N 537				
	Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:  This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure treatments were provided as ordered on the plan of care in 1 of 3 clinical records reviewed of patients with skilled nursing services with the potential to affect		se or the  nd ents e in 1					

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157579		B. WING			R-C / <b>07/2012</b>
NAME OF PE	ROVIDER OR SUPPLIER	137379	STREET ADD	<b>I</b> RESS, CITY, STA	TE, ZIP CODE		10112012
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	M ST TIELD, IN 4601	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 537	Continued From page 13			N 537			
	evidenced a plan of c period 2/24/12 throug home health aide servevidenced a documer Follow-up Assessmer by employee II, that in wound located on the the assessment titled stated, "Turgor: Good wound." The area of "Wound Care" states, nickel, no active drain skin blanching, aroun assessment titled "Wo"Location L [left] heel, Tunneling: no, Odor: and blanching, Edema Appearance: no active area, Drainage / Amo serosanguineous." The "Sore on L [left] heel and symptoms] of infedays per orders."  A. The record exthe certification period that identified the patidiagnosis of diabetes 250.00 and orders that 2 times a day, 7 X W X assessment teach visprn. [if necessary] injections twice daily. every other week and	"Comments: Wound singe / bleeding. Open, go d wound." The area of bund / Lesion" stated, Type: diabetic foot ulc no, Surrounding Skin: ra: +1, Stoma: No, e drainage, yellow serount: none, Color: ne care summary stated size of nickel, no s + s [section. Dressed every 2 widenced a plan of care d 2/24/12 through 4/23/	frd // pleted d one ea of " was pen ize of good the er, ed us d, signs 2  for 12  CM urse]: hen 2 rform and nsulin ns ion				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		` ′	LE CONSTRUCTION	(X3) DATE S COMPL	
				A. BUILDING B. WING	·		R-C
		157579				03	/07/2012
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	PLUM ST 'ERFIELD, IN 46017			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 537	7 Continued From page 14			N 537			
	with gauze wrap then seen by wound clinic SN to monitor dise Cardiac. Perform glu and record. Observe breakdown, and feet clinical record failed to of the wound that incl measurements and the wound bed.	o evidence an assessmuded complete ne appearance of the o	nt is 12. MD / sit of nent				
	B. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/24/12 at 8:30 AM completed by employee KK. The note stated, "PO [oral] meds & [and] insulin given per MD orders dressing intact legs propped up on pillow." The skilled nurse note failed to evidence a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the nurse to administer oral medications.						
	C. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/24/12 at 6:30 PM completed by employee KK. The note stated, "VS [vital signs] in am, pain assessed, OT [unknown] complete, insulin & PO meds [medications] given per MD orders, tolerate well, meal provided dressing intact LE [left extremity] propped up with pillows alert system @ [at] side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications.		:30 tated, well, nity] side." t a nat nat for				
	titled "Nursing Visit N	ecord evidenced docum ote" dated 2/25/12 at 8 ployee KK. The skilled	:30				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	157579			A. BUILDING B. WING		R-C 03/07/2012
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	00:0::=0::=
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	M ST IELD, IN 4601	17	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE	ILD BE COMPLETE
N 537	Continued From page 15			N 537		
	and stated, "Telfa, AE to LLE [left lower extr note failed to evidence assessment was come assessment of both of titled "Nursing Visit NPM completed by em "VS done in am, pair complete, insulin & Porders, tolerate well, @ side." The skilled evidence that a comp completed that include	ecord evidenced documote" dated 2/25/12 at 6. ployee KK. The note so assessed, OT [unknow O meds given per MD meal provided. Alert sy nurse note failed to blete skin assessment welled an assessment of ble record failed to evider	dage rse sents :30 tated, wn] rstem ras oth of			
	titled "Nursing Visit N PM completed by em "VS done in am, pain [unknown] complete, MD orders, tolerate w is clean, dry, and inta Alert system @ side.' failed to evidence tha assessment was com assessment of both or record failed to evide administration of oral  G. On March 7, KK, a licensed praction was not a plan of care she began providing a delivered to the home	npleted that included an of the patient's feet. The nce an order for the	tated,  or per ssing tor.  electrical content of the content of th			

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		457570		B. WING		R-C
NAME OF DE	OVIDER OR SUPPLIER	157579	STREET ADDI	<mark> </mark> RESS, CITY, STA	TE ZIP CODE	03/07/2012
	NDANT CARE		523 W PLU			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
N 537	Continued From page 16			N 537		
	verbal orders given to registered nurse in che 2/21/12. She indicate patient's medications the patient's feet at all She indicated she was the patient's feet was her during the skilled the patient always har both feet and that she assess the skin on the 2. Agency policy #C-of Care" states, "POL are furnished under the of the client's physicial INSTRUCTIONS 1. Care signed by a phy each client receiving locare services."  3. Agency policy #C-"Physician Orders" states dients must be ordered.  4. The policy titled "States "Skilled nursing by a Registered nurse Vocational Nurse und Registered Nurse and	o her from employee F, large of the patient throed she was administering daily and was not cheel during the nursing visits not aware that check a task to be completed nurse visits; she indicated slippers and stocking that have the patients' feet.  580, not dated, titled "FICY Home care service supervision and direct an SPECIAL An individualized Plan sician shall be required thome health and personals."  635, not dated, titled ates, "POLICY All ints and services provided."	ough ong the cking its. ing I by ted s on n to  Plan es ction of I for nal  ed to			
{N 545}	410 IAC 17-14-1(a)(1	)(F) Scope of Services		{N 545}		
	are limited to therapy	nealth setting, the regis				

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING		R-C	
		157579		D. WING		03/07/201	12
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	M ST IELD, IN 460 <sup>,</sup>	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE CO	(X5) DMPLETE DATE
{N 545}	Continued From page 17			{N 545}			
	(F) Coordinate services.						
	interview, the agency registered nurse prov nurse with the physici patient's care could be clinical records review skilled nursing service all the agency's patient.  1. Clinical record 21, evidenced a plan of comperiod 2/24/12 throughome health aide servidenced a documer Follow-up Assessment by employee II, that in wound located on the the assessment titled stated, "Turgor: Good wound." The area of "Wound Care" states, nickel, no active drain skin blanching, aroun assessment titled "We"Location L [left] heel, Tunneling: no, Odor: and blanching, Edema Appearance: no active area, Drainage / Amo serosanguineous." The "Sore on L [left] heels."	ord and policy review and failed to ensure the ided the licensed praction is orders so that the electric coordinated in 1 of 3 and of patients receiving es with the potential to ants. (# 21)  start of care 10/27/11, are for the certification h 4/23/12 with orders for the certification h 4/23/12 with orders for it itled "Recertification of the detailed "Recertification of the area and at the area "Integumentary Status I, Other - L [left] heel, of the assessment titled "Comments: Wound shage / bleeding. Open, of wound." The area of bound / Lesion" stated, Type: diabetic foot ulcono, Surrounding Skin: ra: +1, Stoma: No, et drainage, yellow sero	g affect  or or ord / oleted d one ea of " was pen ize of good i the er, red ous d, [signs				
	days per orders."	videnced a plan of care					

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Indiana State Department of Health

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUF	
		157579		B. WING		R-	
NAME OF D	ROVIDER OR SUPPLIER	15/5/9	STREET ADDRE	ESS CITY STA	TE ZIR CODE	03/0	7/2012
	NDANT CARE		523 W PLUM CHESTERFIE	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{N 545}	that identified the patidiagnosis of diabetes 250.00 and orders that 2 times a day, 3 X [tintimes a day, 7 X W X assessment teach visprn. [if necessary] injections twice daily. every other week and compliance / effects. left heel every other with gauze wrap then seen by wound clinic SN to monitor dise Cardiac. Perform glu and record. Observe breakdown, and feet clinical record failed to fithe wound that incl measurements and the wound bed.  B. The clinical retitled "Nursing Visit New AM completed by em stated, "PO [oral] mee MD orders dressing pillow." The skilled not a complete skin assessincluded an assessment feet. The record faile the nurse to administe C. The clinical retitled "Nursing Visit New AM completed by em "VS [vital signs] in am [unknown] complete,	d 2/24/12 through 4/23/ient had a principle mellitus type II ICD -9-at stated, "SN [skilled nines] W [week] X 1 W, the Sw for: SN to persit and vital signs daily, administer to patient in Preset oral medication. SN to change dress day with sterile telfa, what ace bandage until clier in Connersville on 3/9/rease process of IDDM / cometer check each vis skin for possible signs for proper care." The of evidence an assessmuded complete the appearance of the operation of the patient of both of the pat	CM urse]: hen 2 rform and nsulin ns ion ing to ap nt is 12. MD / sit of nent pen  nents :30  per o on ence that nt's for  nents :30  tated,	(N 545)			

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		, ,	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
	A. BUILDING B. WING				R-0 03/07	C 7/ <b>2012</b>	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CJ'S ABU	CJ'S ABUNDANT CARE 523 W CHEST			M ST IELD, IN 460°	17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{N 545}	Continued From page 19			{N 545}			
	propped up with pillous. The skilled nurse note complete skin assess included an assessmet. The record faile the administration of t	ecord evidenced documote" dated 2/25/12 at 8: ployee KK. The skilled changed a wound dres 8D pad, kerlix, ace bandemity]." The skilled nurse that a complete skin apleted that included an of the patient's feet.  ecord evidenced documote" dated 2/25/12 at 6: ployee KK. The note stances assessed, OT [unknown O meds given per MD meal provided. Alert synurse note failed to elete skin assessment where an assessment of being the provided of the erecord failed to evidentistration of oral ecord evidenced documote" dated 2/26/12 at 6: ployee KK. The note stansessed & charted, Coinsulin & PO meds giver, lineal provided, drested in the provided of the skilled nurse note.	side."  t a nat nat nat's for  nents :30 note ssing dage rse  nents :30 tated, wn] //stem //as oth of nce  nents :30 tated, or nce  nents :30 tated, wn] //stem //as oth of nce				

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		157579		B. WING 03/07			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	ITE, ZIP CODE	•	
CJ'S ABU	NDANT CARE		523 W PLUM CHESTERFIE		17		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE	(X5) COMPLETE DATE
{N 545}	assessment of both or record failed to evider administration of oral.  G. On March 7, 2 KK, a licensed practic was not a plan of care she began providing seed elivered to the home she was providing the verbal orders given to registered nurse in che 2/21/12. She indicate patient's medications the patient's feet at al. She indicated she was the patient's feet was her during the skilled the patient always have both feet and that she assess the skin on the 2. The policy titled "S states "Skilled nursing by a Registered nurse Vocational Nurse und Registered Nurse and medically approved P orders).  3. On March 6, 2012, indicated there was repolicy or procedure for	pleted that included an f the patient's feet. The nee an order for the medications.  2012 at 10:08 AM, employers in the home from the end in the home from employee F, arge of the patient through the home from employee F, arge of the patient through and was not cheef during the nursing visits onto aware that check a task to be completed nurse visits; she indicated slippers and stocking that hot removed then the patients' feet.  Skilled Nursing Services are the supervision of a din accordance with a lan of Care (physician's patients), at 4:22 PM, employee of an approved agency or the communication	oloyee re time ated rfrom the ough ng the cking its. ing I by ted s on n to	(N 545)	DEFICIENCY		
N 608	provided patient care. 410 IAC 17-15-1(a)(1	-6) Clinical Records		N 608			
	Rule 15 Sec. 1(a) Cli	nical records containing	g				

Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		457570		A. BUILDING B. WING			R-C
NAME OF BE	ROVIDER OR SUPPLIER	157579	STREET ADD	RESS, CITY, STA	TE ZIP CODE	03	/07/2012
CJ'S ABUNDANT CARE			523 W PLU				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 608	Continued From page 21			N 608			
	pertinent past and cur with accepted profess maintained for every (1) The medical plaidentifying informatio (2) Name of the phypodiatrist, or optomet (3) Drug, dietary, tre (4) Signed and date to by all assigned pebe written the day ser incorporated within fo (5) Copies of summ person responsible for the patient's care. (6) A discharge sum This RULE is not me Based on clinical recoagency failed to ensure the maintained if record for 1 of 5 records revipotential to affect all person include:	rrent findings in accordational standards shall be patient as follows: In of care and appropriation. It is i	ate actor, ders. uted shall ent of				
	1. Clinical record # 21 failed to evidence care was provided to the patient from February 27, 2012, through March 4, 2012.		-				
	2. On 3/6/12 at 11:45 AM, employee FF indicated the nurse visit notes for the care provided on February 27 through March 4, 2012, for patient # 21, were not available and had been placed into the mail. They expected the notes to be delivered by the United States postal service on Wednesday March 7, 2012.						
	3. On 4:30 PM on 3/6	6/12, employee FF indi	cated				1

Indiana State Department of Health STATE FORM

Indiana State Department of Health

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLI IDENTIFICATION NL			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUI COMPLET		
		IDENTIFICATION NOMBI	LIV.	A. BUILDING		R-	-C	
		157579		B. WING			7/2012	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CJ'S ABU	NDANT CARE		523 W PLU CHESTERF	M ST FIELD, IN 460°	17			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
N 608	Continued From page 22			N 608				
	protect and identify we chart documents were they could become to 4. On 3/7/12 at 12 P they received their m	ave a policy or procedure what should be done where placed in the US mail ost.  PM, employee FF indicate and delivery for the day anical record # 21 had no	en and red and					
N 614	N 614 410 IAC 17-15-1(c) Clinical Records			N 614				
	shall be safeguarded use. Written procedu removal of records a information. Patient's required for release oby law. Current serviat the parent or branservices are provided discharged from serviced away from the provided they can be seventy-two (72) hou become current serviced mitted to service.  This RULE is not me Based on clinical recagency failed to ensurance agency failed to ensurance with the provided they can be seventy-two (72) hou become current services.	vice. Closed files may be parent or branch office we returned to the office wars. Closed files do not ice files if the patient is e.  Let as evidenced by: Lord review and intervieware all clinical records wars for 1 of 5 records the potential to affect all	orized d e of pe rized ned vithin					
	Findings include:							
		21 failed to evidence can patient from February 2 14, 2012.	-					

Indiana State Department of Health

STATE FORM 6899 6WIQ13 If continuation sheet 23 of 24

Indiana State Department of Health

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPP IDENTIFICATION I	(X1) PROVIDER/SUPPLIER/		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY  COMPLETED		
7.1.12 . 27.11 0		IDENTIFICATION NOME	EK.	A. BUILDING	<u> </u>		R-C	
	157579			B. WING			/07/2012	
NAME OF PE	ROVIDER OR SUPPLIER	10.0.0	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		70172012	
TO THE OT THE	OVIDER OR OUT FEEL		523 W PLU	T ADDRESS, CITY, STATE, ZIP CODE				
CJ'S ABU	NDANT CARE		CHESTER					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 614	N 614 Continued From page 23			N 614	DEFICIENC	<u></u>		
	the nurse visit notes February 27 through 21, were not available the mail. They expedelivered by the Unit Wednesday March 73. On 4:30 PM on 3 the agency did not he protect and identify we chart documents we they could become left. On 3/7/12 at 12 February their markets and their markets we they received their markets.	ted States postal service 7, 2012. /6/12, employee FF indi ave a policy or procedu what should be done wh re placed in the US mai	ent # into e on cated re to len I and					

Indiana State Department of Health STATE FORM